unacceptable side effect when the medication is used properly in a rational and appropriate fashion.

Dr Daniell also stated that secondary infection is a "frequent complication of conventional therapy." His experiences regarding secondary infection must certainly be unique and perhaps are worth reporting in a double-blind controlled research study.

In summary, in my opinion, hot showers are not to be generally recommended to all patients with rhus dermatitis, especially due to the potential side effects of such therapy. The benefits from more conventional therapy such as systemic steroids properly utilized are worthwhile for achieving resolution of a troublesome dermatitis.

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Do-Not-Resuscitate Orders

TO THE EDITOR: Regarding the letter from medical student Marc Tunzi on do-not-resuscitate orders,[1] I am delighted that medical students have such sensitivity. Please remember, Mr Tunzi, that the house officers you so disdain for determining no-code status in such rapid fashion are trained by the staccato pace of the clinical arena where delay and indecision in evaluation of, say, respiratory failure or meningitis can lead to disaster. They know likewise that even short delay of no-code orders leads not to happy outcomes but to painful and degrading perpetuation of painful illness that is agonizing to both patients and their families.

Save a copy of your letter, Mr Tunzi, and after your next 12 long months of internship, read it again. You will realize how much you have grown and how much more complex your world has become.

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1. Tunzi M: Do-not-resuscitate orders and the doctor-patient relationship (Correspondence). West J Med 1984 Apr; 140:620-621

Ending Physician Maldistribution

TO THE EDITOR: I wish I could be as positive as Crowder and associates[1] over the results of the California AHEC program. Nowhere does the "Program Results" section report on how many health professionals have actually settled in the medically underserved portions of the state. I propose a different system to end physician maldistribution.

We seem to have a physician glut and a coexisting and paradoxical physician shortage. One cause of this phenomenon could well be the large debt that a young physician accumulates during medical training. It is an economic fact that it is easier to pay off this debt when you practice in a large population center.

The costs of office equipment and supplies are the same whether a physician practices in a small community or a large one. Rents and office help cost only a little less in a small town—not enough to make up for lower income and a slower debt reduction. It is surely recognized by all young interns that a neurologist or an orthopedist or even a pediatrician will have fewer cases and less income in a small, rural catchment area. A physician's time is less effectively utilized when he or she travels to four or five hospitals, 50 miles from one another, to see one patient in each hospital. The unproductive travel time lowers his or her income even further. What would be the incentive, therefore, to practice in a small-income, rural area, watching his or her debt diminish ever so slowly every year?

My suggestion to narrow this debt/rural practice gap is to forgive medical school debts in exchange for a contract to practice within a rural county or low-population area for a specified number of years. If we can develop a financial instrument whereby an association of rural counties or even a small-population state would pay off medical education-related debts in return for a multi-year contract, we could perhaps get a lot of young doctors with up-to-date medical education practicing in the outlying areas not only for the duration of their contract periods but also afterwards because they had become used to the pleasures of a low-pressure life in a small community. Hunting, fishing, horse-breeding all come easier in the country and many physicians, as other people, enjoy this life. This could be the method to have country pleasures—and provide good care to small-town populations.

As it is now, we are trying to catch our tails: we produce more physicians just to see them settling in Los Angeles, for example (and hoping to "graduate" eventually to Beverly Hills), and the original goal of producing physicians to end the physician shortage in the rural areas keeps eluding us. The financial tool could be the ending of capitation grants to medical schools and using the same money for debt reduction by giving it to rural county plans. Of course, we may forgive the debts of young graduates who would have located in underserved, rural counties anyway (although there can't be many, based on currently known preferences) but if there were a perfect system of putting out our money with 100% efficiency, we, and especially the federal government, have yet to find it.

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REFERENCE

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